AMERICAN OSTEOPATHIC ASSOCIATION

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Statement of the American Osteopathic Association to the Practicing Physicians Advisory Council

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The American Osteopathic Association (AOA) appreciates the opportunity to provide a statement to the Practicing Physicians Advisory Council regarding the proposed **Revisions to Payment Policies under the Medicare Physician Fee Schedule for CY 2006.** Our comments focus on the Sustainable Growth Rate (SGR).

The AOA, which represents the nation's 56,000 osteopathic physicians practicing in 23 specialties and subspecialties, remains concerned that the continued use of the flawed and unstable SGR methodology will result in a loss of physician services for millions of Medicare beneficiaries.

The Centers for Medicare & Medicaid Services (CMS) currently forecast an update of a negative 4.3 percent in 2006 with further negative updates in later years. Underlying the payment rate reductions is "substantial growth in Medicare spending," according to CMS. The agency attributes the spending growth in 2004 to the following five areas:

- An increase in spending for office visits, with a shift toward longer and more intense visits;
- Greater use of minor procedures, including physical therapy and drug administration;
- More patients receiving more frequent and more complex imaging services, such as MRIs and echocardiograms;
- More laboratory and other physician-ordered tests;
- Higher use of physician-administered prescription drugs.

CMS says it would like to understand these trends further, including which changes in utilization are likely to be associated with important health improvements and which ones may have more questionable health benefits.

Utilization is often beyond the control of the physician or physicians as a whole. Over the past twenty years, public and private payers successfully shifted the delivery of health care away from the hospital into physicians' offices. They did so through a shift in payment policies,

coverage decisions, and a move away from acute based care to a more ambulatory based delivery system. This trend continues today. As a result, fewer patients receive care in an inpatient hospital setting. Instead, they rely upon their physicians for more health care services, leading to greater utilization of physician services.

Since its inception in 1965, a central tenet of the Medicare program is the physician-patient relationship. Medicare beneficiaries rely upon physicians for access to all aspects of the Medicare program. Over the past few years, this relationship has become compromised by dramatic reductions in reimbursements, increased regulatory burdens, and escalating practice costs.

For the past several years, CMS has failed to account for the numerous policy changes and coverage decisions in the SGR spending targets. With numerous new beneficiary services included in the Medicare Modernization Act and an expected growth in the number of national coverage decisions, utilization is certain to increase over the next decade. The Congressional Budget Office (CBO) cited legislative and administrative program expansions as major contributors to the recent increases in Medicare utilization. The other major contributors were increased enrollment and advances in medical technology.

While physicians can take some steps to streamline their business operations, they simply cannot afford to have the gap between costs and reimbursements continue to grow. Many of our members practice in solo or small group settings. Such small businesses have a difficult time absorbing these losses. Eventually, the deficit will be too great and physicians will be forced to limit, if not eliminate, services to Medicare beneficiaries. Given that the number of Medicare beneficiaries is expected to double to 72 million by 2030, now is the time to establish a stable and accurate physician payment formula that reflects the cost of providing care.

The current payment formula penalizes physicians with lower payments when utilization exceeds the SGR spending target. It is important to note that physicians are the only Medicare providers subjected to this type of payment structure. Hospitals, nursing homes, and others do not face the possibility of "real dollar" cuts—only adjustments in their rates of increase. We believe that physicians should be reimbursed in a more predictable and equitable manner, similar to other Medicare care providers.

Congress and physician associations, including the AOA, have urged CMS to use its authority to make administrative changes in the SGR formula, such as removing Part B drug payments. The definition of physician services included in Section 1848 of Title XVIII does not include prescription drugs or biological products. We are disappointed that CMS has not removed drug payments from the SGR calculation. Including drug payments greatly affects the amount of actual expenditures and unfairly reduces payments for physician services.

Quality and Payment Reform

However, we do commend CMS's efforts to engage the medical community in developing measures to promote higher quality of care. Today's health care consumers—including Medicare beneficiaries—demand that physicians and other providers provide the highest quality of care per health care dollar spent. The AOA recognizes that quality improvement in the

Medicare program is an important and worthy objective. For over 130 years osteopathic physicians have strived to provide the highest quality care to their patients.

As a physician organization, we are committed to ensuring that all patients receive the appropriate health care based upon their medical condition and the latest research information and technology. The AOA recognized the need for quality improvement and the national trend toward quality improvement programs. In response, we took several steps to ensure that our members were educated, aware, and prepared for these new programs.

Our May 22, 2005 statement to PPAC introduced the association's Clinical Assessment Program (CAP). The CAP measures quality improvements in current clinical practices in osteopathic residency programs. The goal is to improve patient outcomes by providing valid and reliable assessments of current clinical practices. The program has been widely praised and is starting to produce data on the quality of care provided. The CAP is able to collect data from multiple clinical programs and provide information regarding performance back to participating programs. This allows for evaluation of care provided at a single practice site in comparison to other similar practice settings around the region, state, or nation.

In September of this year, the CAP will be available for physician offices. The "CAP for Physicians" will measure current clinical practices in the physician office and compare the physician's outcomes measures to their peers and national measures. The AOA looks forward to working with Congress and CMS to explore ways that the CAP may be incorporated into broader quality reporting and quality measurement systems.

CMS plans to intensify its efforts in developing quality measures and the means of sharing information related to quality of care and use of resources with individual physicians. CMS anticipates that only data showing the quality of care and resource use in the aggregate would be released to the public. The agency wants to build on recent progress on payment reforms to promote higher quality and avoid unnecessary costs, while not increasing overall Medicare costs.

As CMS explores quality reporting and pay-for-performance, the AOA established a set of principles that guide our efforts on these issues. The following principles provide a set of "achievable goals" that assist in the development of quality improvement systems while recognizing the skill and costs benefits of physician services.

American Osteopathic Association
Policy Statement on Physician Payment, Quality Improvement, and Pay-for-Performance

The American Osteopathic Association (AOA) believes that the current Medicare physician payment formula, especially the sustainable growth rate (SGR), is seriously flawed and should be replaced. The AOA strongly supports the establishment of a new payment methodology that reimburses physicians appropriately for the costs of providing care to their patients. The AOA is committed to ensuring that any new physician payment methodology reflects the quality of care provided and that efforts are made to improve the health outcomes of patients. As a result of this

commitment, we support the establishment of standards that, once operational, will allow for the reporting and analysis of reliable quality data. Additionally, we support the establishment of a fair and equitable evaluation process, or pay-for-performance goal that aims to improve the quality of care provided to beneficiaries. To support this goal, the AOA adopted the following principles.

1. The American Osteopathic Association (AOA) supports the establishment of quality reporting and/or pay-for-performance systems whose primary goal is to improve the health care and health outcomes of the Medicare population. The AOA believes that such programs should not be budget neutral. Appropriate additional resources should support implementation and reward physicians who participate in the programs and demonstrate improvements. The AOA recommends that additional funding be made available through the establishment of bonus-payments.

2. The American Osteopathic Association (AOA) believes that to the extent possible, participation in quality reporting and pay-for-performance programs should be voluntary and phased-in. The AOA acknowledges that failure to participate may decrease eligibility for bonus or incentive-based reimbursements, but feels strongly that physicians must be afforded the opportunity to not participate.

3. The American Osteopathic Association (AOA) recommends that physicians be central to the establishment and development of quality standards. A single set of standards applicable to all physicians is not advisable. Instead, standards should be developed on a specialty-by-specialty basis, applying the appropriate risk adjustments and taking into account patient compliance. Additionally, quality standards should not be established or unnecessarily influenced by public agencies or private special interest groups who could gain by the adoption of certain standards. However, the AOA does support the ability of appropriate outside groups with acknowledged expertise to endorse developed standards that may be used.

4. The American Osteopathic Association (AOA) does not support the exclusive use of claims-based data in quality evaluation. Instead, the AOA supports the direct aggregation of clinical data by physicians. Physicians or their designated entity would report this data to the Centers for Medicare and Medicaid Services (CMS) or other payers.

5. The Federal government must adopt standards prior to the implementation of any new health information system. Such standards must ensure interoperability between public and private systems and protect against exclusion of certain systems. Interoperability must apply to all providers in the health care delivery system, including physicians, hospitals, nursing homes, pharmacies, public health systems, and any other entities providing health care or health care related services. These standards should be established and in place prior to any compliance requirements.

6. The American Osteopathic Association (AOA) encourages the Federal government to reform existing Stark laws, allowing physicians to collaborate with hospitals and other physicians in the pursuit of electronic health records systems. This will promote widespread adoption, ease the

financial burden on physicians, and enhance the exchange of information between physicians and hospitals located in the same community or geographic region.

7. The American Osteopathic Association (AOA) supports the establishment of programs to assist all physicians in purchasing health information technology (HIT). These programs may include grants, tax-based incentives, and bonus payments through the Medicare physician payment formula as a way to promote adoption of HIT in physician practices. While small groups and solo practice physicians should be assisted, programs should not expressly exclude large groups from participation.

8. The American Osteopathic Association (AOA) supports the establishment of programs that allow physicians to be compensated for providing chronic care management services. Furthermore, the AOA does not support the ability of outside vendors to provide such services.

Conclusion

The SGR methodology is broken and, in our opinion, beyond repair. The U.S. House Ways and Means Health Subcommittee, the Medicare Payment Advisory Commission (MedPAC), and every physician organization recommends eliminating the formula and replacing it with a payment system that more accurately reflects the costs of providing care to beneficiaries. Physicians cannot afford to have continued reductions in reimbursements. Ultimately, they will either stop participating in the Medicare program or limit the number of beneficiaries they accept into their practices. Either of these scenarios results in decreased access for our growing Medicare population.

We are generally supportive of programs aimed at improving the quality of care provided and believe that we have a responsibility to help CMS craft such a program. However, we do not and will not support programs whose sole goal is to reduce or curb spending on physician services. The goal must be improved health care for beneficiaries, which in the short-term likely will result in increased, not decreased, spending.

Additionally, we believe it is time to consider changes in the Medicare funding formulas that allow for spending adjustments based upon the financial health of the entire Medicare program. We believe that as Congress and CMS establish new quality improvement programs, it is imperative for Medicare to reflect fairly the increased role of physicians and outpatient services as cost savers to the Part A Trust Fund.

Quality improvement programs may increase spending in Part B, but very well could result in savings in Part A or Part D. These savings should be credited to physicians through a "gainsharing" program between Parts A, B, and D. As quality reporting and pay-for-performance programs become more prevalent, fundamental issues must be addressed. Some of our top concerns are:

- Programs must be developed and implemented in a way that aims to improve the quality of care provided by all physicians. New financial formulas must provide financial incentives to those who meet standards and/or demonstrate improvements in the quality of care provided. The system should not punish some physicians to reward others.

- The use of claims data as the sole basis for performance measurement is a concern. Claims data does not reflect severity of illness, practice-mix, and patient non-compliance. These issues and others are important factors that must be considered. The sole reliance on claims data may not indicate accurately the quality of services being provided. We believe that clinical data is a much more accurate indicator of quality care.

- Minimize the financial and regulatory burden these programs will have upon physician practices, especially those in rural communities. Physicians, and medicine in general, have one of the highest paperwork burdens anywhere. We want to ensure that the establishment of new programs doesn't add to physicians' already excessive regulatory burden.

- Programs should have some degree of flexibility. The practice of medicine continuously evolves. Today's physicians have knowledge, resources, and technology that didn't exist a decade ago. This rapid discovery of new medical knowledge and technology will transform the "standards of care" over time. It is imperative that the quality reporting and pay-for-performance system have the infrastructure to be modified as advances are made.

The AOA stands ready to work with Congress and CMS to develop a payment methodology that secures patient access and appropriately reimburses physicians for their services. Also, we stand ready to assist in the development of new programs that improve quality, streamline the practice of medicine, and make the delivery of health care more efficient and affordable.